IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 22, 2010

Richard Bangert
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bangert:

On **February 12, 2010**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004424

Allegation: A patient was put in isolation room and placed on a liquid diet to make the patient compliant with treatment.

Findings: An unannounced visit was made to the hospital on 2/10/10 through 2/12/10. Fifteen medical records were reviewed. Restraint logs were reviewed. Patients were observed. Staff were interviewed.

Restraint logs for the past 4 months were reviewed. The hospital had a low rate of the use of restraint and/or seclusion on adult and adolescent units.

One medical record documented a 14 year old male who was a patient at the hospital from 11/04/09 to 12/01/09. Diagnoses included bipolar disorder and reactive attachment disorder. Numerous notes documented the patient was very defiant and acting inappropriately. The notes stated he frequently yelled, swore, and tried to intimidate staff and peers. No evidence was present the patient was punished for this behavior. On 11/20/09 at 2:00 PM, the nurse documented the patient was angry and intimidating toward staff and peers. The note stated the patient showed his journal, which was full of drawings of drugs and guns, to peers.

The note said the patient was loud an invasive. He was moved to the quiet room. He was given Zyprexa per physician order. He was not prevented from leaving but he did stay in the quiet room until lunch. He napped after lunch and then saw the physician. The nursing note, at 9:45 PM on 11/20/09, stated the patient had been up and active on the unit in the afternoon and evening. The notes were clear the patient was not secluded.

The nurse who moved the above patient to the quiet room, was interviewed on 2/11/10 at 11:45 AM. She stated the patient went to the quiet room voluntarily on 11/20/09. She said he was loud and defiant but would cooperate with staff requests. She stated he was not prevented from leaving the room. She also stated no dietary restrictions were placed on the patient.

The same patient had a physician's order on 11/24/09 for an "ad lib diet". The order stated the patient could have a full liquid diet if he wanted. The physician progress note, dated 11/24/09, stated the patient complained of an upset stomach so the physician asked staff to give him some soup.

The Dietary Manager was interviewed on 2/10/10 at 1:55 PM. She stated the above patient complained of nausea and requested a full liquid diet for lunch. She stated he became hungry later that afternoon. She said he asked for and was placed back on a regular diet. She stated she could not think of an instance where food was used for behavioral reasons.

The medical records of two patients, who had been placed in seclusion and/or restrained, were reviewed. They contained documentation of compliance with regulatory requirements related to isolation.

No instances were identified where food was used to influence a patient's behavior. Seclusion and restraint use was low and guidelines for their use had been followed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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February 25, 2010

Richard Bangert
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bangert:

On **February 12, 2010**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004431

Allegation #1: The hospital was not handicap accessible.

Findings: An unannounced visit was made to the hospital on 2/10/10 through 2/12/10. Fourteen medical records were reviewed. A tour of the hospital was conducted. Hospital policies were reviewed. Patients were observed. Staff were interviewed.

Two medical records documented adult patients with physical disabilities who were in-patients at the hospital within the past four months. One patient was housed on the adult unit and one patient was housed on the psychiatric intensive care unit.

The medical record of the patient on the adult unit stated she had a diagnosis of multiple sclerosis. The record contained a note by the Occupational Therapist which recommended a room with a "handicap accessible bathroom." The patient was placed in a room with a handicap accessible bathroom at that time. Later during her stay, she was transferred to another unit which did not have a patient room with a handicap accessible bathroom.

The other medical record documented a patient with paraplegia who was confined to a wheelchair. He was housed on a unit which did not have a patient room with a handicap accessible bathroom.

A tour of the hospital was conducted on the afternoon of 2/11/10 at 9:55 AM. Surveyors were accompanied by the Nursing Services Coordinator. It was observed that none of the adult rooms was equipped with accommodations for people with physical disabilities such as grab bars and accessible toilets, sinks, and/or showers. The only room equipped with these amenities was located on the male adolescent unit. This was confirmed by the Nursing Services Coordinator at the time of the tour.

While the complaint was substantiated, the need for accessibility was not clearly addressed by federal and state hospital regulations. The complaint was forwarded to the Office For Civil Rights, located in Seattle, Washington, for follow up.

Conclusion: Substantiated. No deficiencies related to the allegation are cited. Referral to the appropriate agency.

Allegation #2: Staff did not make allowances for a patient with a physical disability. The patient was provided with a standard wheel chair. The patient had to walk around it to lock and unlock the brakes. It kept tipping and the patient fell once due to the chair. Staff would not assist the patient to get another chair. Staff made the patient go to groups even though the patient was exhaused. Staff made the patient come to the nursing station to medication and would not bring it to the patient's room. Staff would not push the patient in the wheel chair and would not let other patients push the patient.

Findings: Two medical records documented adult patients with physical disabilities who were in-patients at the hospital within the past four months. One patient was housed on the adult psychiatric unit and one patient was housed on the psychiatric intensive care unit. Both records documented staff assisted the patients with their physical needs if they required assistance. No inpatients required wheelchairs at the time of the survey.

The medical record of the patient on the psychiatric intensive care unit documented the patient was independent with most transfers and activities of daily living. He was provided assistance with showering.

The medical record of the patient on the adult unit documented the patient's diagnoses were opioid dependence and depression. An Occupational Therapy evaluation had been completed. The evaluation stated the patient had a wheelchair at home. However,the evaluation stated the patient was able to ambulate in the hallway without the use of a wheelchair.

The evaluation stated the patient was independent with dressing, hygiene, grooming, feeding, toileting, and transfers. The evaluation recommended the patient be placed in a room with a handicap accessible bathroom.

The medical record of the patient on the adult unit contained a two page plan of care related to the patient's physical disability. The plan outlined an ambulation and energy conservation plan. A physician order stated the patient was to use the wheelchair for ambulation. Several nursing progress notes stated the patient wanted staff or other patients to push her to groups and activities. The patient was told other patients were not to push her in the wheelchair. One note stated the patient had other patients push her when she thought she would not get caught. Two possible falls were documented in the medical record. One note stated the patient said she fell but there was not evidence of this. One note stated the patient fell while getting into bed. Neither alleged incident was witnessed. Throughout the patient's stay, progress notes stated the patient wanted to be pushed in a wheelchair and staff wanted her to be independent. Occupational therapy worked with the patient throughout her stay.

The Nursing Supervisor was interviewed on 2/10/10 at 11:25 AM. She stated both the physician and the occupational therapist wanted the patient to be as independent as possible. She stated the patient was encouraged to ambulate using the wheelchair, to go to the nurses' station for medications, and to attend all groups. She also confirmed other patients were told not to assist the patient.

The Occupational Therapist was interviewed on 2/10/10 at 11:25 AM. She stated the above patient was able to ambulate and plan was to encourage the patient to be as independent as possible. She stated staff were directed not to push the patient in the wheelchair unless she really needed the assistance.

Patients with physical disabilities were not present in the hospital during the survey. Only one patient, who had been confined to a wheelchair, had resided at the hospital in the past six months. The medical record documented he had received assistance with bathing and had not needed other assistance.

Staff provided needed assistance to patients with disabilities.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw